

Working for Patients: NHS reform and drug budgets

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In our series on the history of prescribing policy, Dr Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he describes the controversial reforms introduced following the publication of *Working for Patients* in 1989.

KEY EVENTS

- **1989** *Working for Patients* published – controversial plans to reform the NHS and to introduce financial budgeting for NHS medicines expenditure
- **1991** NHS reforms introduced – radical reforms introduced to much political opposition and public hostility
- **1991** Family Health Services introduced – FHSAs replaced FPCs, with the former being given management powers over general practice

After 12 months of secret planning, the Conservative's plans for reforming the NHS were outlined in *Working for Patients*, published in January 1989.¹ The white paper voiced government concerns over public spending on drugs: 'Expenditure on medicines has grown on average by 4 per cent a year above the rate of inflation over the past five years', and the cost of the drugs is 'more than the cost of the doctors who wrote the prescriptions'.

Not only were worries expressed about the growth in the drugs bill, but the policy document also announced the government's desire to reduce unexplained variations in prescribing costs, which had been found to exist between different GPs and regions in the UK. At the time, the average cost of the prescriptions dispensed in the 90 English Family Health Services Authorities (FHSAs) varied between £33.30 and £59.65 per patient, around a mean of £47.66, with sizeable variations also existing between practices within the various areas.²

As a means of controlling the growth and variation in pharmaceutical costs, *Working for Patients* announced that, from April 1991 onwards, each practice would be given a prescribing budget under the auspices of the practice budget and the indicative prescribing schemes. Under the new arrangements, practices that elected to join the former scheme would initially receive a budget allocation from their regional health authority. Other, non-budget holding practices would automatically receive a prescribing allocation from their local family practitioner committees (FPCs).

Although further information was promised, the white paper dedicated only six sides to the construction and implementation of the practice budget scheme (later referred to as the 'fundholding scheme') and two pages to the introduction and operation of (what were later termed) 'indicative prescribing amounts (IPAs)'.

Soon after the publication working for patients, the Association of the British Pharmaceutical Industry (ABPI) commissioned the management consultants Touche Ross to review the likely effects of the reforms on the UK medicines market and pharmaceutical industry.³ In its analysis, the company suggested that GP prescribing was likely to be affected by the budget-setting formulae used to allocate funds to individual practices and the response of family doctors to the budgets that they were set.

Depending upon how these factors interacted, the paper suggested that 'one off' changes in prescribing behaviour could occur. In particular, budgeting could stimulate increased generic prescribing, improved repeat prescriptions and a shift to over-the-counter medicines. However, the growth in drug expenditure could be reduced by 2.5 per cent, without damaging the market for new medicines or having an adverse effect on patient care.

While Touche Ross gave some support to the budget-holding idea, the company was less approving of the plan announced in *Working for Patients* to encourage FPCs and district health authorities to jointly develop local formularies to help non-fundholding practices stay within their IPAs. Indeed, the consultants argued that local formularies were difficult to develop, reduced the prescriber's clinical freedoms and could delay the use of beneficial new drugs. In turn, these effects could stifle innovation, reduce the availability of niche products and decrease competition in the pharmaceutical market. As a result, the patient, the UK pharmaceutical industry and the economy could all suffer.

In April 1990, the King's Fund published a briefing paper written by David Taylor, a fellow in health policy analysis at the institute, and Professor Alan Maynard of the University of York, which examined the relationship between the UK pharmaceutical industry and NHS medicines expenditure.⁴ In their paper, the authors placed the proposals for fundholding and indicative prescribing budgets in the context of other government prescribing initiatives.

Among a number of questions posed, the authors asked:

- Should supply-side price and profit control systems be replaced by demand-side restraints like health service budgets?
- What place does generic prescribing and formularies have in future medicine cost-control strategies?

In response to the first question, the authors argued that the introduction of prescribing budgets could raise public fears about rationing, lead to uneconomic reductions in costs and, if they totally replaced the Pharmaceutical Price Regulation Scheme (PPRS), would allow some companies to make considerable profits from the NHS.

In reply to the second, Taylor and Maynard argued that too simplistic or rigid an approach to increasing generic prescribing or constructing local formularies (eg automatic substitution or compulsory compliance) could stifle innovation and therapeutic development. As a result, patient choice, the economy and the finances of the UK's research-based pharmaceutical companies could all be affected.

In response, the authors suggested that when examining the ability of the schemes to control practice-level drug costs consideration should also be given to their effects on: the overall rationality of GP prescribing, the performance in all related parts of the NHS and the country's research-based pharmaceutical companies.

FPCs to FHSA

To support the reform process, FPCs were transformed into FHSAs in 1991. As part of its plans to improve general practice prescribing the government gave FHSAs a greater role in managing and controlling local prescribing patterns and costs.

As part of their new responsibilities they were expected to help recruit GPs to the fundholding scheme and monitor their expenditures against the budgets that they were set, establish a medical audit framework for local practices, and set and monitor IPAs for non-fundholding practices.

Despite the complexity of these tasks FHSAs, initially received little guidance on how they should prepare themselves for their new responsibilities or how to prioritise their allotted tasks.

To help the bodies fulfil their new roles and responsibilities, chief executive posts were created in all FHSAs and, during this period, most authorities began to employ professionally-qualified medical and pharmaceutical advisors.

As part of these new arrangements chief executives were instructed to set targets for improving local prescribing behaviour, and medical and pharmaceutical advisors were expected to become involved in practice visits, budget-setting and the auditing of Prescribing Analysis and Cost (PACT) data.⁵

To help both parties complete their allotted tasks, in 1992 the Prescription Pricing Authority (PPA) made practice-level available electronically to all FHSAs, followed two years later by electronic data at an individual drug level.

The shifting of drug costs from cash-limited hospital budgets on to local practices was one of first prescribing policy problems that FHSAs faced. Although guidance on prescribing responsibilities had been issued in February 1987 by the acting Chairman of the NHS Management

board, Sir Leonard Peach, many hospitals had ignored his advice.

As a result, in June 1990 the NHS Management Executive was forced to establish a working group on prescribing responsibilities between hospitals and GPs. To help with their study, the group received a report written by a research team at St. George's Hospital, London, which stated that an increasing number of hospitals were limiting the amount of drugs that they supplied upon discharge, with the result that some GPs were being asked to prescribe products for which they did not want clinical responsibility.⁶

Following the submission of the working group's report, the Management Executive issued guidance on the sharing of prescribing responsibilities between hospitals and GPs.⁷ Among its main recommendations the guidance:

- suggested that the doctor with clinical responsibility should also have the prescribing responsibility
- focused on the concept of 'shared care' and the need for proper hand-over procedures
- recommended that a discharged patient

should receive seven days' supply of necessary medicines (unless shorter courses were required)

- stated that DHAs and fundholders should specify product provision responsibilities in the secondary-care contracts that they signed.

Although these recommendations had the potential to solve the problems associated with pharmaceutical cost-shifting, FHSAs were expected to implement them without any formal powers over local provider units. Indeed, the authorities were being asked to realise a policy objective that their constitution gave them little ability to meet.

Conclusion

Working for Patients announced the Conservative's plans to introduce direct financial controls on family doctor prescribing. This was a radical reform, which had previously been suggested on several occasions but which no previous government had dared to attempt. The result of this unexpected and widely unpopular popular policy was widespread discontent among many general medical practitioners and

patients. Despite opposition, the Conservative government persevered and pharmaceutical budgeting first introduced in 1991 still remains in the NHS today.

References

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In the next installment in the series, Dr Baines will analyse the operation of government prescribing policy in the late-1980s and 1990s.